Patient Education in Primary Care

Volume 8 Issue 4 April 2005

contents

Welcome to our resource for patient education and primary care![1]

WHAT IS IT?

This newsletter provides a mechanism to help meet the challenges of incorporating effective patient education into primary care.

WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators and Patient Health Education Committee members, VISN and VAMC decision makers.

Patient Education Initiatives Support Performance Measures

This article features several patient education programs and activities implemented at VA health care facilities to support clinical performance measures.

VISN 10

The VISN 10 Patient Health Education Council has instituted seven programs to improve performance measures and customer satisfaction scores for the VA health care facilities in Ohio. Deborah Crabtree, Chair of the VISN Council and Patient Health Education Coordinator at VAMC Chillicothe, says, "Effective patient education contributes to improved health outcomes, so we want to provide the best patient education services we can to veterans in this VISN." The services include:

- Best Patient Education Practices—the Council selects priority focus areas, and council members facilitate the multidisciplinary work groups that include content experts appointed from each facility to develop the

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best practices. The work group's proposal is presented to the PHE Council, then to the VISN Clinical Care Council for approval and implementation at each site. To date, best practices have been established for smoking cessation, exercise and weight management, diabetes, stroke, and patient orientation.

- Veterans Health magazine—this quarterly publication focuses on high priority topics and performance measures and offers information to veterans on health promotion, prevention and maintenance. It is mailed to 180,000 veterans throughout the VISN and also can be read online at the VISN 10 website (http://www.visn10.med.va.gov).
- Kiosks—touch screen units have been installed at each facility. During FY-05, kiosks are also being installed in each community-based outpatient clinic to give veterans immediate access to health information. The kiosks use Health Point software which is updated regularly. Usage data are analyzed to determine the types of health information veterans are seeking and to identify needs of veterans in VISN 10.
- Orientation packet—the Council created the packet following focus reviews at each site that asked veterans what they wanted to know about VISN 10 and what items would benefit them the most. The packets are provided to veterans at their first point of contact with VA health care services and contain: a welcome letter; information on VA services and resources including contact information; a patient and family health education folder with a variety of pamphlets; a magnet with telephone numbers for the VISN 10 telephone care program and the VA hotline; and a listing of VISN 10 health care facilities and contact information. Additional information is added at the local level based on veterans' needs.
- *Healthwise for Life* manuals and online resources—last fiscal year, over 128,000 self-help manuals customized by the Patient Health Education Council were provided to veterans in VISN 10 at their entry points for care. The initiative will continue until all enrollees have received a manual. The VISN also purchased the *Healthwise Knowledgebase* internet site which offers additional health information and access to online support and self-help groups. It can be accessed through the VISN 10 website.
- Veterans Health Calendars—The VISN 10-customized health calendars feature monthly topics related to the performance measures and preventive health information are provided to veterans.
- Be Informed–Ask Questions—the VISN 10 Patient Stakeholder Service Council, with collaboration from the Patient Health Education Council, developed a flyer to help veterans prepare for a clinic visit. The flyer addresses five topics: medications and treatments; health problems; concerns patients may have; tests (if ordered); and follow-up care. The goal of this initiative is improvement in customer satisfaction scores.

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Tuscaloosa VAMC

"At our facility we use a team approach to performance improvement," said Lisa Holloway, quality standards nurse at the facility. "The team includes the Performance Improvement Coordinators from primary care and mental health, the EPRP Coordinator, the Patient Education Coordinator and the Chief of Staff who is very committed to performance improvement. We implement rapid cycles of improvement. Each time we initiate a new intervention, we study it closely to see if it's working," she said

Staff have developed a series of smoking cessation pamphlets based upon the stages of change model. In primary care, nurses talk with the patients and give them the appropriate pamphlet and the schedule for smoking cessation classes if they're interested. "Since many of our patients come long distances to the medical center, two years ago we started offering telephone consultation for smoking cessation, including the nicotine patch and Buproprion, for patients who want to quit but can't come to the classes," said Holloway. "We have trained additional facilitators on smoking cessation—one per inpatient unit and one per clinic—and have created a resource notebook for each clinician that includes the guidelines, resource information and the pamphlets. As a result of these initiatives, last year we saw improved smoking cessation outcomes in primary care and achieved 100% on our tobacco counseling score," she said.

Patients with an elevated LDL receive a lipid management education letter in the clinic along with a handout that explains dietary approaches to reducing lipid levels and instructions for fasting prior to laboratory tests measuring lipid levels. The handout, developed by a dietitian, was also placed on the desktops of all clinicians so they would have ready access to this tool for educating patients on lowering LDL and raising HDL levels. "Lipid management is one area Tuscaloosa VAMC is still working to improve," said Holloway, "but progress is being made due to the focus on patient education."

VA Connecticut Health Care System

"Each month we select one of the performance measure topics and highlight it as the Feature of the Month," says Joanne Messore, Patient Education Coordinator. "During that month, we place a display table in front of the learning center with a variety of materials about the topic, we show relevant videos on our closed circuit TV system in the clinics and the inpatient rooms, and we place relevant materials about the topic in the primary care areas," she added.

"The Feature of the Month presents a good opportunity to educate patients and answer specific health care questions they may have," she said. "Of course, these materials—both print and audiovisual—are available to patients throughout the year as well. Print materials are written at two grade levels and in two languages, and audiovisual materials can be checked out by patients for home viewing" she said. "Our learning center is a busy place. Last year we had visits from 26,000 patients to obtain information or attend classes held here," Messore said.

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VAMC San Juan

At this facility, every patient with a diagnosis of congestive heart failure receives a telephone call from a nurse to educate and counsel them about managing their health problem. Each patient also receives a mailed brochure on managing CHF. Elba Nieves, Nursing Patient/Family Health Education Coordinator, says that this intervention has been very well received by patients and has helped improve the facility's score on the CHF performance measure.

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Patient Education/Primary Care Program Notes

VISN 8 Health Literacy Activities

The Patient Education Work Group in VISN 8 has implemented a number of activities to address the issue of health literacy. Some of the initiatives are VISN-wide and some are being tested in single facilities.

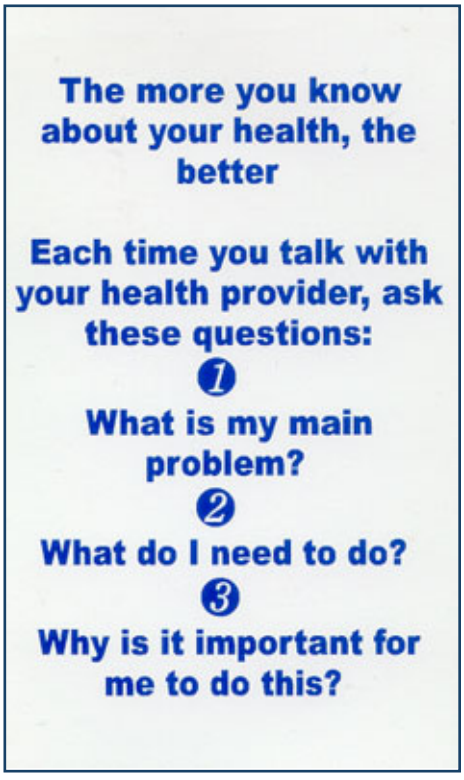
VISN-wide Activities

All the health care facilities in the VISN participate in the Ask Me 3 program, which focuses on three questions patients are encouraged to ask their clinicians:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

In addition to program brochures, the facilities use window clings on outpatient exam room doors and inpatient room doors that list the three questions in order to remind patients and clinicians about the questions. They also review the program with new patients at their orientation sessions. (For more information about the Ask Me 3 program, see the article on page 8 in this issue.)

All the facilities offer education to clinical staff on health literacy. At Miami health literacy is addressed during orientation for new residents,



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at staff meetings, and at meetings of primary care staff. At Gainesville, health literacy is addressed during orientation and nursing inservice sessions both at the medical center and at satellite clinics. Tampa has developed a web-based course on health literacy that offers 0.5 hours of patient safety credit. Any VA facility can download the course and adapt it to its own facility.

The Patient Education Work Group, co-chaired by Janet Schneider, Patient Education Librarian at VAMC Tampa, and Tim Lawler, Psychologist at VAMC Miami, is attempting to standardize patient education materials produced in-house at VISN facilities. "Each facility has its own review process for patient education materials," said Schneider. "We're trying to weed out poor materials and those written at reading levels too high for patients," she added. "Since we can upload patient education materials into iMed," said Lawler, "we want to make sure they're good."

In VISN 8 a person representing patient education sits on the iMed consent work group at each facility. "Our goal," said Lawler, "is to draft or modify existing consent forms so they're at the fifth grade reading level."

Dr. James Borland, Associate Chief of Staff for Outpatient Clinics in North Florida and South Georgia, sits on the board for health literacy of the American Medical Association. "He's been a champion for health literacy with the VISN leadership," said Schneider. "For example, the VISN Health Services Committee is considering the idea of adding health literacy as a flag in CPRS which would stay on for all clinicians seeing that patient," she said.

VAMC Miami

This facility is the first in the VISN to receive the latest version of the CPRS clinical reminder package. As a result, Miami will be able to add an item for low literacy to the list of potential barriers to patient education.

VAMC Gainesville

Patricia Donaldson, Clinical Care Manager, is testing a brief questionnaire to assess health literacy in two primary care clinics. The screening questions were developed by three physician researchers at the VA Puget Sound Health Care System in Seattle. Of the sixteen items in their questionnaire, three questions were found to be effective in uncovering inadequate health literacy among the 332 patients they tested in a VA pre-operative clinic:

- How often do you have someone help you read hospital materials?
- How confident are you filling out medical forms by yourself?
- How often do you have problems learning about your medical condition because of difficulty understanding written information?

"I first used this approach with 15 patients whom I knew and had worked with for some time," said Donaldson. "I predicted how they would answer the questions, and then they rated themselves when they came in for their visits. To my surprise, I was off by 50%—either over- or under-estimating their self-ratings," she said. "These patients reported more difficulty understanding oral instructions than written information," she added. "So now I'm more careful with my verbiage when giving oral instructions, and I draw a lot more pictures. I'm also surveying another 50 patients using an additional question regarding spoken information and instructions," she said.

The VISN 8 Patient Education Work Group will review the findings to determine whether this approach should be tested more widely as a method to assess health literacy among veteran patients.

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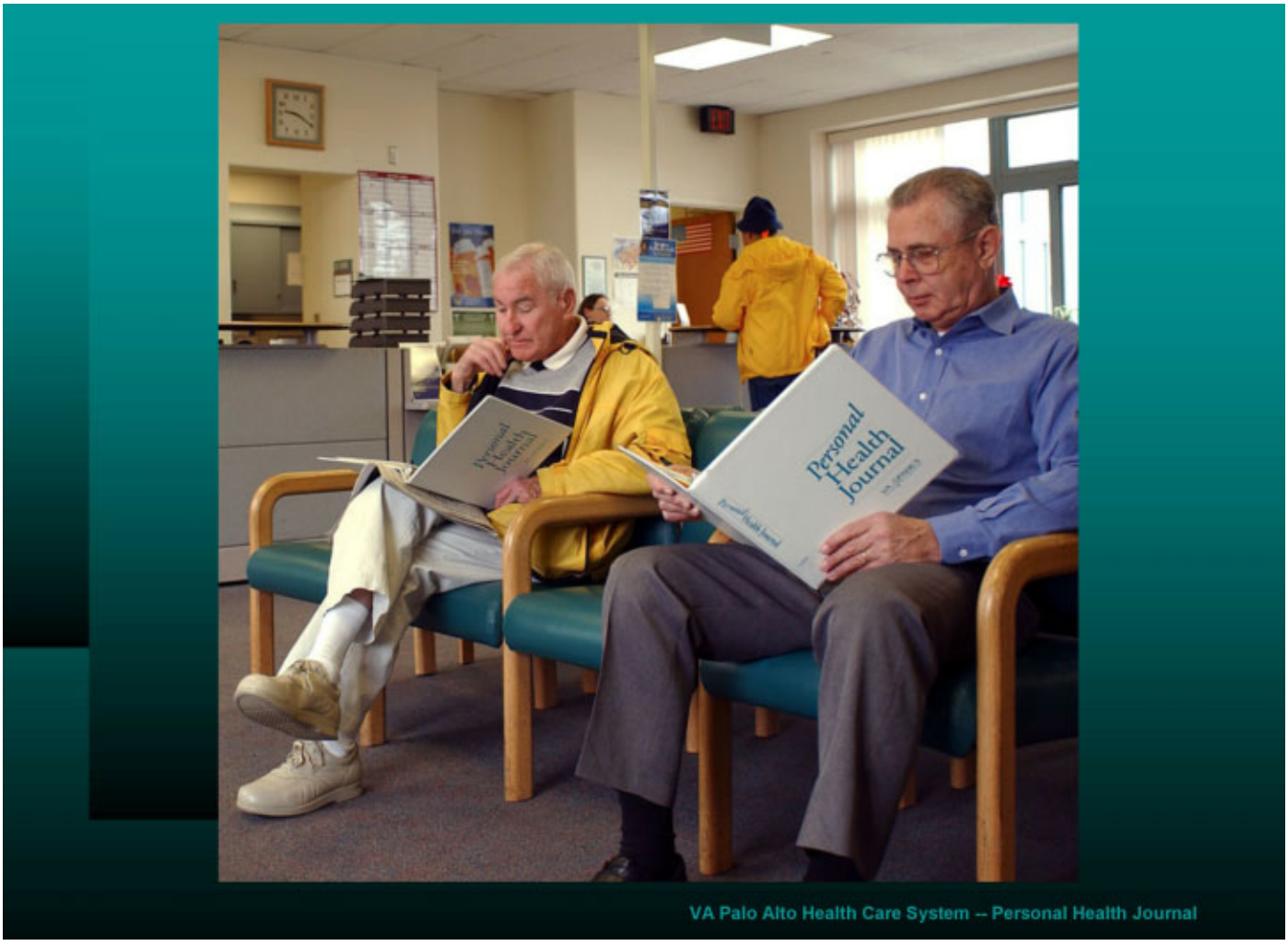
Personal Health Journals for Patients

At the VA Palo Alto Health Care System (VAPAHCS), personal health journals have been distributed to almost 40,000 patients enrolled in all primary care clinics at the nine system sites. "Patients tell us they really like the journal. Every day we see lots of patients carrying their journals with them to their appointments," said Rosemary Gill, Patient Education Coordinator, who, with a quality manager, initiated the project in 1999.

At that time VAPAHCS patient satisfaction scores for primary care were low in two aspects: patient education and visit coordination. Patients wanted more information about who was in charge of their care, what actions to take if their problems or symptoms worsened, medication changes, lab and test results, and pending appointments.

The personal health journals were created to address those concerns. The 3-ring binder contains each patient's personal health information, such as his/her current problem list and medication schedule, most recent test results, and a list of future appointments. The journal also contains the name and contact information for the patient's primary care provider. Another section includes personal health promotion information such as due dates for vaccines, diabetic foot checks and eye examinations. The binder also includes brochures describing how to use the telephone care program and the pharmacy refill system, how to follow safe medication practices, and how to prepare advance directives. An introductory letter explains the purpose of the journal and issues regarding release of information. The letter emphasizes the partnership between patient and provider in sharing health information.



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New enrollees receive their binders and instructions for using them at the patient orientation session. At each primary care visit the patient receives from the clerk a personalized Patient Health Summary listing the patient's active problems, provider contact information, most recent test results, current medications, upcoming appointments and health maintenance status. The patient also receives a cover letter explaining the process and encouraging the patient to review the health summary information and formulate any questions for the provider. The intake nurse gives the patient a binder if he/she does not already have one and briefly explains its purpose and structure. The provider reviews the Patient Health Summary with the patient during the visit. The patient is responsible for bringing the journal to all clinic appointments and admissions.

Staff time to deliver the binders and summaries to patients averages 1-5 minutes. Since providers were already reviewing content covered in the personalized summaries with patients, the journals may add 30 seconds per patient to the visit time but may save providers time by keeping patients focused.

The project was implemented over a 2-1/2 year period following a 6-month pilot study at one clinic site. Feedback from staff, providers and patients during the pilot phase guided the changes made to the journal and to the process. Funding was provided through the Office of Education. Binders are purchased fully assembled through a Government Printing Office contract.

During the implementation phase, the facility's quarterly patient education newsletter featured an article about the personal health journals. They were also featured as a bulletin board topic in all primary care clinics. Inservice sessions were conducted to help familiarize staff with the journal, and clinic intake nurses received "talking points" to help them explain the purpose and use of the journal when giving it to a patient.

A preliminary evaluation of the personal health journals has been conducted at one of the sites. Patients were surveyed using a quasi-experimental pre-test/post-test design. Six months after implementation of the personal health journal, improvement was seen in 8 of the 9 areas of patient education.

"Developing content for the personal health journals was a challenge," said Gill. "We sought advice from VA legal counsel who advised us that the contents of the personal health journals did not require formal release of information protocols. That was a major factor in overcoming initial staff concerns about the project. We also had to modify VistA programming in order to provide individual patient information for the Patient Health Summary. Providers, staff and patients gave lots of advice about content topics and format," she added.

"The personal health journals have produced many benefits for all of us," said Gill. "When we started the project, we had no standard protocol for sharing test results with patients. The personal health journals provided a structure for this, so patients and providers know they'll be reviewing test results from the patient's personal health summary at each visit. Of course, patients are contacted by phone regarding any lab values requiring intervention before the next scheduled visit," she said.

"The Personal Health Journal is a useful tool for patients because they can review their health information any time they wish or share it with family or non-VA providers," Gill said.

"Most importantly, the journal enhances the partnership between providers and patients. Reviewing the individual patient health summary at each visit helps the patient build trust in the clinician, and maintaining the journal and bringing it to each visit lets the clinician know the patient wants to be actively involved in his care," Gill added.

For further information contact:

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Patient Education Resources

Ask Me 3

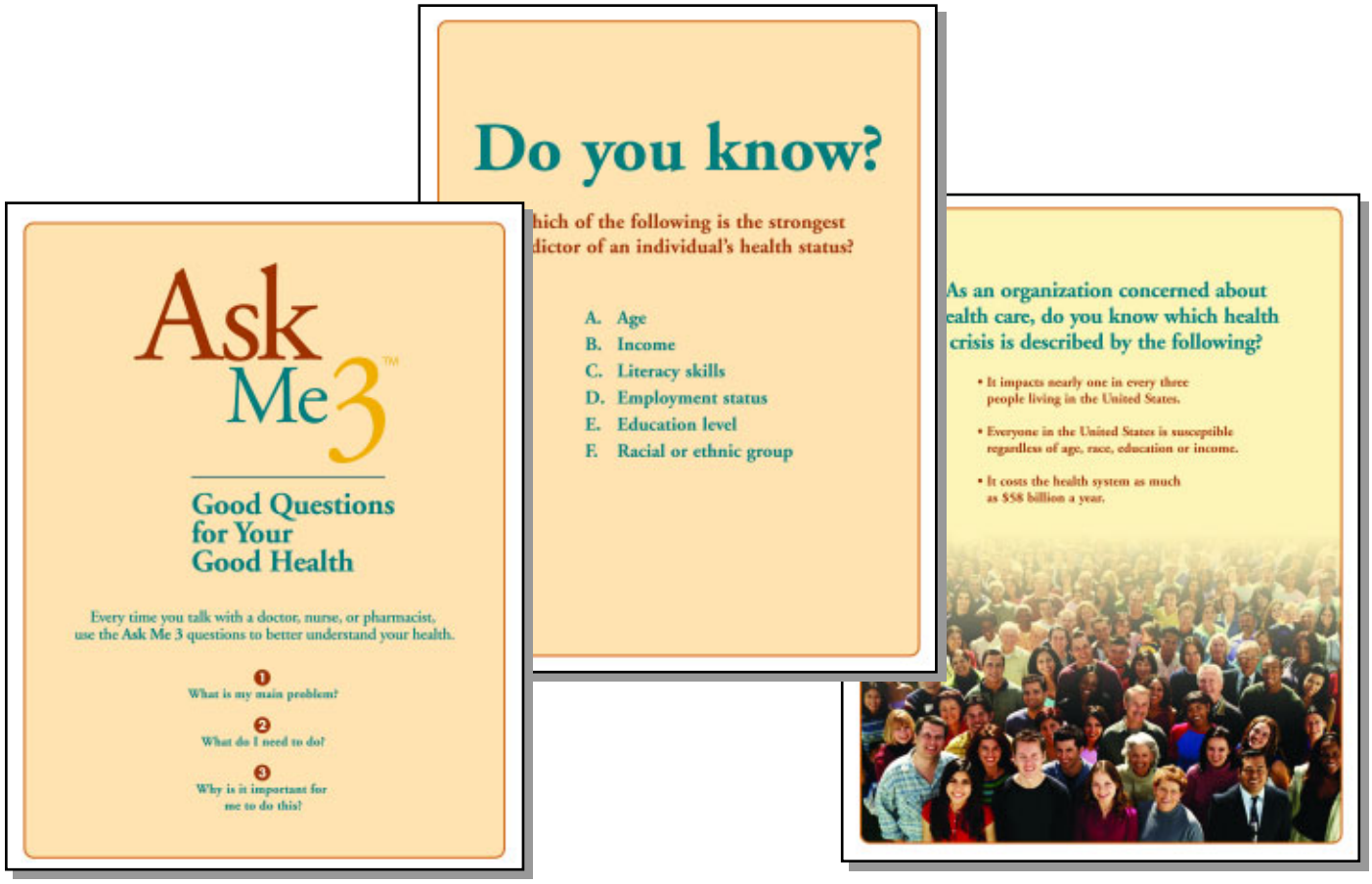
Ask Me 3 is a program designed to promote clear health communication between patients and health care providers. It focuses on three questions patients are encouraged to ask their clinicians:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

The program is sponsored by the Partnership for Clear Health Communication, a coalition of national health organizations working to promote awareness and solutions around the issue of low health literacy and its effect on health outcomes. Materials include free brochures in English and Spanish directed to three audiences—patients, health care providers, and health care organizations.

The patient brochure explains when to ask the questions, offers tips for clear health communication, and provides space for the patient to write in current medications and treatment instructions. The provider brochure describes health literacy and its clinical impact, addresses several myths about health literacy, and offers suggestions for incorporating health literacy strategies into patient visits. The organization brochure describes the clinical and economic impact of health literacy and lists a variety of action strategies to use with staff, constituents and public officials to address the issue of low health literacy.

Program materials and additional information are available at www.AskMe3.org and by phone at 1-877-4-ASK-ME-3.



Teach Tip

Communicating with Family Members

Most clinicians welcome interaction with the family members of their patients. The clinician learns more about the family dynamic and the level of support the patient can expect in helping him manage his health problems, and the family members get to know the clinician and learn what they can do to help their family member. In the process, the positive relationship between clinician and patient that is the foundation for successful communication and treatment is extended to include key people in the patient's life.

But sometimes communication with family members can be difficult. One challenging situation is when several members of the family want to communicate independently with the clinician. This can occur when adult children of the patient live in different parts of the country, but each one calls the clinician for updates on their parent's care. It can also occur when family members are not on speaking terms with each other or disagree with each other, so each one calls the clinician to get the "real" story.

What can the clinician do to honor the relationship with the patient, yet manage the demands of multiple phone calls or e-mail messages? Here are some strategies that may help:

- acknowledge to the patient that the situation is causing you difficulty; if the patient is not alert or able to participate in this conversation, discuss the situation with a key family member
- point out that your goal is to provide the best care to the patient while keeping the family informed, but you're not willing to compromise the first goal for the second
- describe the consequences for your schedule and the care of your patients when you must spend time repeating the same information for several individuals in the same family
- emphasize that you want to communicate with them and you want them to communicate with you, but together you have to find a way that is manageable for all of you
- suggest that the family designate one individual as the liaison for communication with you and encourage them to relay their questions and concerns through that person so you can address everyone's issues
- follow through with the family liaison, taking care to acknowledge the family's concerns and answering their questions as fully as possible
- or consider a regularly scheduled conference call so everyone can participate at the same time
- make an agreement to try the selected approach for a specific period of time with an option to change if it's not working for you or the family.

How do we know patient education works?

Patient-Reported Medication Symptoms in Primary Care

This study, conducted at Beth Israel Deaconess Medical Center in Boston, was designed to assess variables that affect physician-patient communication about medication symptoms in primary care. Participants included 661 patients who received prescriptions from physicians at four adult primary care practices. Investigators interviewed patients at 2-weeks and 3-months after the index visit, reviewed their medical records, and surveyed physicians whose patients reported medication-related symptoms. Physician reviewers determined whether the reports constituted true adverse drug events.

One hundred seventy-nine patients reported 286 medication-relation symptoms, but discussed only 196 (69%) of the symptoms with their physicians. Physicians changed the treatment in response to 76% of the reported symptoms. Patient failure to discuss symptoms resulted in 19 ameliorable and 2 preventable adverse drug events. Physician failure to change treatment in 48 cases resulted in 31 ameliorable adverse drug events.

Using multivariate analyses, investigators determined that patients who took more medications and had more medication allergies were significantly more likely to discuss symptoms. Male physicians, and those at two of the practices, were significantly more likely to change treatment.

The authors conclude that primary care physicians may be able to reduce the severity and/or duration of adverse drug events by eliciting and addressing patient medication symptoms.

Weingart SN, Gandhi TK, Seger AC, Seger DL, et al. (2005) Patient-reported medication symptoms in primary care. Archives of Internal Medicine, 165(2):234-40.

Designing a Knowledge Scale for Patients with Diabetes and Poor Literacy

The intent of this study was to develop and validate a 10-item spoken knowledge scale to be used with patients who have Type 2 diabetes and poor literacy skills. The instrument, SKILLD (Spoken Knowledge in Low Literacy patients with Diabetes), was tested among 217 patients with Type 2 diabetes and poor glycemic control at a general medicine clinic at Vanderbilt University Medical Center in Nashville, TN.

Mean age of participants was 55 years. The patients had had diabetes for an average of 8.4 years, and 38% had less than a sixth-grade literacy level. Less than one-third of the participants knew the signs of hypoglycemia or the normal fasting blood glucose range.

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Internal reliability of the instrument measured 0.72 using the Kuder-Richardson coefficient. Higher scores on the instrument were significantly correlated with higher income, education level, literacy skills, duration of diabetes, and lower A1C levels. Patients with lower scores on the instrument had significantly higher A1C levels, a difference that remained significant when adjusted for covariates.

The authors conclude that the SKILLD instrument is internally consistent and valid, and that it is a practical scale for Type 2 diabetic patients who have low literacy skills.

Rothman RL, Malone R, Bryant B, et al. (2005) The Spoken Knowledge in Low Literacy in Diabetes scale: a diabetes knowledge scale for vulnerable patients. Diabetes Educator, 31(2):215-24.

Agreement between Clinician and Patient Assessments of Symptoms in Gastroesophageal Reflux Disease

This study analyzed data from four randomized clinical trials involving over 2600 patients treated with one of four gastroesophageal reflux disease medications or placebo.

The analysis was designed to determine the extent of agreement between clinicians and patients regarding the severity of symptoms before and after 4 to 8 weeks of treatment, and for absence of symptoms after treatment.

Before treatment, agreement between clinicians and patients regarding symptom severity was poor to moderate: 24-35% for epigastric pain; 36-43% for regurgitation; 48-52% for heartburn; and 63% for dysphagia. Poor agreement resulted from clinician under-estimation of symptom severity compared to patient ratings of severity in three of the studies, and clinician over-estimation in one study.

Agreement improved following treatment: 42-60% for epigastric pain; 58-78% for heartburn; 66-76% for regurgitation; and 86% for dysphagia. Agreement was highest for patients reporting no further symptoms, and it decreased with increasing severity of symptoms.

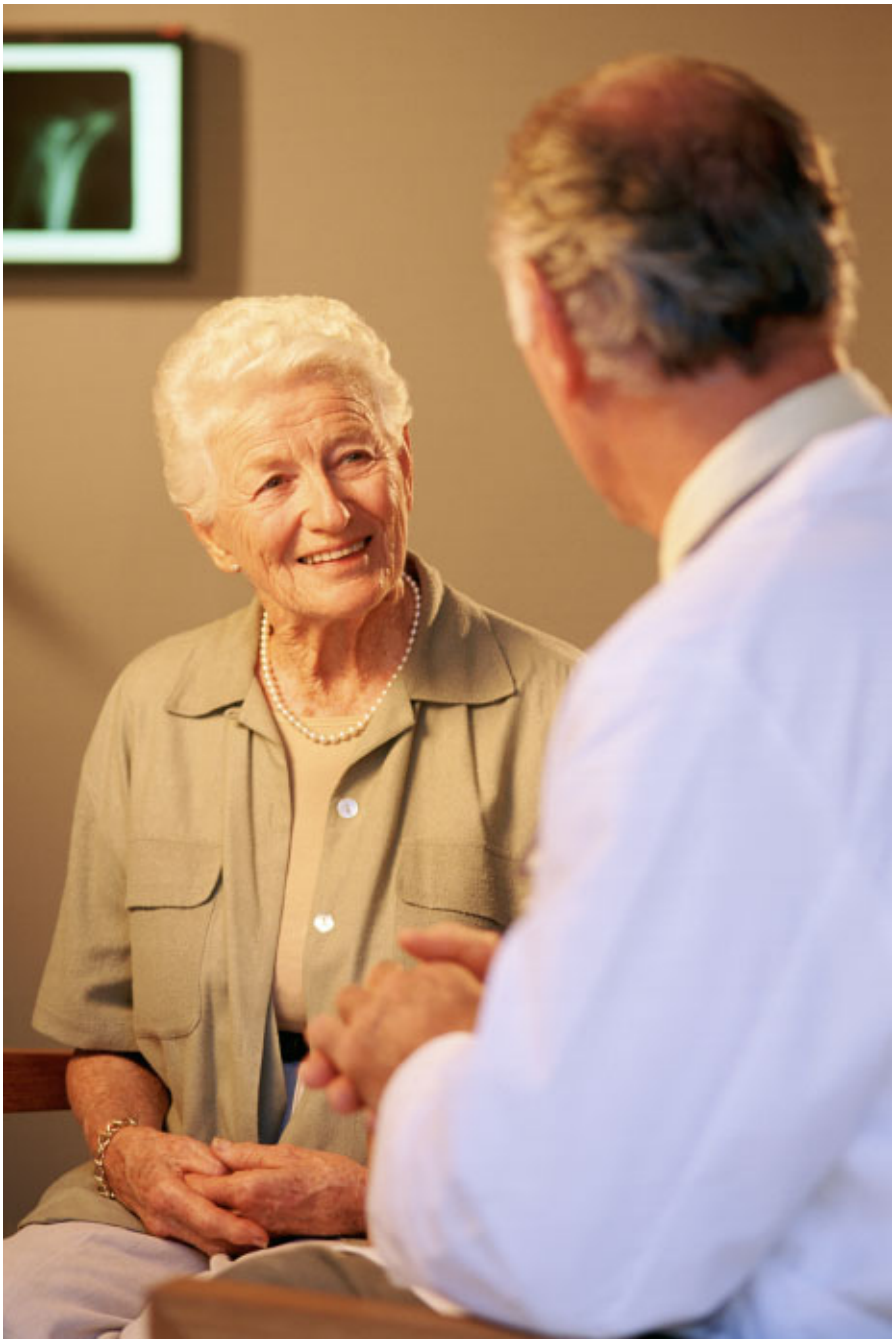
The authors conclude that improvements in clinician-patient communication may help to increase the level of agreement, and that greater reliance on patient assessments may be appropriate.

McColl E, Junghard O, Wiklund I, Revicki DA. (2005) Assessing symptoms in gastroesophageal reflux disease: how well do clinicians' assessments agree with those of their patients? American Journal of Gastroenterology, 100(1):11-18.

Improving Osteoporosis Treatment Following Hip Fracture

The purpose of this prospective, randomized trial conducted at the Hospital for Special Surgery in New York City was to determine whether a patient education intervention increased the percentage of patients receiving osteoporosis treatment following a hip fracture. Participants included 80 patients admitted with a low-energy hip fracture. Their average age was 82 years, and 78% of the patients were female.

Intervention group patients engaged in a 15-minute discussion about the association between osteoporosis and hip fracture, diagnostic and treatment procedures, and the importance of medical follow-up for osteoporosis management. These patients were also given five questions regarding osteoporosis treatment to be shared with their primary care physician, and they received reminder calls about the questions six weeks later. Control group patients received a brochure on methods to prevent falls. Both groups received telephone calls at six months post-discharge to determine whether osteoporosis had been addressed by their primary care physicians. At follow-up, a significantly higher number of intervention group patients were receiving treatment for osteoporosis.



The authors conclude that patients who received information and questions for their primary care physicians about osteoporosis were more likely to receive treatment than patients who had not received the information and questions. They also suggest that orthopedic surgeons have a unique opportunity to improve the rate of osteoporosis treatment following a hip fracture by educating patients and guiding them toward long-term osteoporosis management.

Gardner MJ, Brophy RH, Demetrakopoulos D, Koob J, et al. (2005) Interventions to improve osteoporosis treatment following hip fracture: a prospective, randomized trial. Journal of Bone and Joint Surgery, 87(1):3-7.

Performance Improvement Training

Every quarter, *Patient Education in Primary Care* will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit, choose one of the following two options:

Read the entire April 2005 newsletter and provide brief answers to the questions below. Turn these in to your supervisor along with a copy of the newsletter

OR

Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter and discuss the questions below. Turn in a master list of participants along with a copy of the newsletter.

Questions:

1. In what ways does patient education support achievement of performance measures at your facility? What suggestions would you make to enhance these efforts?
2. What strategies are currently used at your facility to identify and help patients with limited health literacy? What can you do to help?
3. How might personal health journals be used with veterans in your facility? Are there other products that could be developed for veterans to address priority health concerns?
4. What strategies are used in your facility to help patients and clinicians communicate better with each other? What suggestions would you make to enhance these efforts?

DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact any of the following with your input:

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Coming in JULY:

Patient Education in Group Clinics

PATIENT HEALTH EDUCATION IN PRIMARY CARE TASK FORCE:

This newsletter is transmitted electronically to VHA staff. To add colleagues to the distribution list, contact your local patient education coordinator or committee chairperson.

Employee Education System

Office of Primary and Ambulatory Care

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES